		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 S. CICERO AVE. (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (847) 371-0400 **Fax #** (847) 371-5871

IDPA ID Number: 36-3967295

Date of Initial License for Current Owners: 08/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	303	110,595	1
2		Skilled Pediatric (SNF/PED)			2
3	199	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	303	TOTALS	303	110,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,111	1,428	13,526	30,065	8
9	SNF/PED					9
10	ICF	50,525	4,641	6,068	61,234	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,636	6,069	19,594	91,299	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 303 and days of care provided 8,631

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	478,988	43,809	22,232	545,029		545,029	(640)	544,389			1
2	Food Purchase		323,798		323,798		323,798	(1,645)	322,153			2
3	Housekeeping	321,465	52,506		373,971		373,971	(3,919)	370,052			3
4	Laundry	121,814	37,462	6,936	166,212		166,212	(567)	165,645			4
5	Heat and Other Utilities			172,021	172,021		172,021		172,021			5
6	Maintenance	86,009	42,727	58,957	187,693		187,693	1,637	189,330			6
7	Other (specify):*			98,143	98,143		98,143		98,143			7
8	**TOTAL General Services**	1,008,276	500,302	358,289	1,866,867		1,866,867	(5,134)	1,861,733			8
	B. Health Care and Programs											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	3,635,163	237,697	65,625	3,938,485		3,938,485	11,412	3,949,897			10
10a	Therapy	133,282		12,731	146,013		146,013		146,013			10a
11	Activities	255,049	5,027		260,076		260,076	(694)	259,382			11
12	Social Services	154,428		8,109	162,537		162,537		162,537			12
13	Nurse Aide Training											13
14	Program Transportation			43	43		43		43			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,177,922	242,724	121,508	4,542,154		4,542,154	10,718	4,552,872			16
	C. General Administration											
17	Administrative	165,548		1,035,422	1,200,970		1,200,970	(1,006,457)	194,513			17
18	Directors Fees											18
19	Professional Services			465,847	465,847		465,847	14,945	480,792			19
20	Dues, Fees, Subscriptions & Promotions			92,432	92,432		92,432	(59,532)	32,900			20
21	Clerical & General Office Expenses	278,579	56,806	107,975	443,360		443,360	151,950	595,310			21
22	Employee Benefits & Payroll Taxes			1,022,841	1,022,841		1,022,841		1,022,841			22
23	Inservice Training & Education			10,693	10,693		10,693		10,693			23
24	Travel and Seminar			350	350		350	17,892	18,242			24
25	Other Admin. Staff Transportation			8,889	8,889		8,889		8,889			25
26	Insurance-Prop.Liab.Malpractice			379,233	379,233		379,233	32,362	411,595			26
27	Other (specify):*			184,624	184,624		184,624	(184,624)				27
28	**TOTAL General Administration**	444,127	56,806	3,308,306	3,809,239		3,809,239	(1,033,464)	2,775,775			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,630,325	799,832	3,788,103	10,218,260		10,218,260	(1,027,880)	9,190,380			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,405	
	REPAIRS & MAINTENANCE		827	
			0	22,232
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,936	
			0	6,936
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		66,976	
	ELECTRICITY		84,122	
	WATER		20,886	
	CABLE TV - LOBBY		37	
			0	172,021
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,860	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		30,784	
	ELEVATOR MAINTENANCE & REPAIR		10,638	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,125	
	FIRE SERVICE		6,550	
			0	
			0	
			0	58,957
7	**OTHER**			
	SCAVENGER		26,125	
	SECURITY SERVICE		72,018	98,143
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	35,000	35,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,627	
	PHARMACY CONSULTANT	XVIII B 39-2	3,600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	56,398	
	WOUND CARE CONSULTANT	XVIII B 46-2	3,000	
			0	65,625
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		4,740	
	SPEECH THERAPY SERVICES		2,582	
	OCCUPATIONAL THERAPY SERVICES		5,409	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	12,731
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	8,109	
			0	8,109
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		43	43
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,035,422	1,035,422
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	61,731	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	404,116	
			0	465,847
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	43,315	
	EMPLOYEE WANT ADS	XIX F	12,218	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	15,088	
	LICENSES & PERMITS	XIX F	1,331	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	14,220	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,246	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,014	92,432
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		17,048	
	OUTSIDE CLERICAL SERVICES		5,025	
	PENALTIES / OVERDRAFT CHARGES	VI 18	25,146	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		788	
	TELEPHONE		57,543	
	MESSENGER SERVICE		2,425	
			0	107,975

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	419,555	
	UNEMPLOYMENT COMPENSATION	XIX D	62,444	
	WORKERS COMPENSATION INSURANCI	XIX D	122,361	
	HOSPITALIZATION INSURANCE	XIX D	403,151	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,980	
	EMPLOYEE PHYSICAL EXAMS	XIX D	160	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	11,190	
	CHICAGO HEAD TAX	XIX D	0	1,022,841
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,693	10,693
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	350	
			0	
			0	350
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,889	8,889
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		379,233	379,233
27	**OTHER**			
	BAD DEBTS	VI 24	184,624	
			0	184,624

GRAND TOTAL COLUMN 3 OTHER 3,788,103

CRESTWOOD CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	323,798	PATIENT MEALS	273897
LESS SALES TAX	(1,645)	ADD EMPLOYEE MEALS	0
NET FOOD	322,153	TOTAL MEALS/YEAR	273897
TOTAL PATIENT CENSUS	91,299	NET FOOD	322153
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	273897
TOTAL PATIENT MEALS	273897	COST PER MEAL	1.18
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			141,260	141,260		141,260	123,937	265,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,811	121,811		121,811	657,345	779,156			32
33	Real Estate Taxes			417,929	417,929		417,929		417,929			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,154,207)	28,393			34
35	Rent-Equipment & Vehicles			46,814	46,814		46,814	11,970	58,784			35
36	Other (specify):* STORAGE			4,887	4,887		4,887		4,887			36
37	**TOTAL Ownership**			1,915,301	1,915,301		1,915,301	(360,955)	1,554,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,157	558,513	879,670		879,670		879,670			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,893	165,893		165,893		165,893			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		321,157	724,406	1,045,563		1,045,563		1,045,563			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,630,325	1,120,989	6,427,810	13,179,124		13,179,124	(1,388,835)	11,790,289			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,884)	30		9
10	Interest and Other Investment Income	(11,176)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,645)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(25,146)	21		18
19	Entertainment		20		19
20	Contributions	(4,246)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,472)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(184,624)	27		24
25	Fund Raising, Advertising and Promotional	(43,315)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(14,220)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(17,606)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (355,334)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,033,501)	PG 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,033,501)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,388,835)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3,768	6	1
2	VACATION ACCRUAL	(640)	1	2
3	VACATION ACCRUAL	(3,919)	3	3
4	VACATION ACCRUAL	(567)	4	4
5	VACATION ACCRUAL	(2,131)	6	5
6	VACATION ACCRUAL	(6,152)	10	6
7	VACATION ACCRUAL	(694)	11	7
8	VACATION ACCRUAL	(7,271)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,606)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(640)	0	0	0	0	0	0	0	0	0	0	(640)	1
2	Food Purchase	(1,645)	0	0	0	0	0	0	0	0	0	0	(1,645)	2
3	Housekeeping	(3,919)	0	0	0	0	0	0	0	0	0	0	(3,919)	3
4	Laundry	(567)	0	0	0	0	0	0	0	0	0	0	(567)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,637	0	0	0	0	0	0	0	0	0	0	1,637	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,134)	0	0	0	0	0	0	0	0	0	0	(5,134)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,152)	17,564	0	0	0	0	0	0	0	0	0	11,412	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(694)	0	0	0	0	0	0	0	0	0	0	(694)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,846)	17,564	0	0	0	0	0	0	0	0	0	10,718	16
	C. General Administration													
17	Administrative	0	(1,006,457)	0	0	0	0	0	0	0	0	0	(1,006,457)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,472)	10,495	6,922	0	0	0	0	0	0	0	0	14,945	19
20	Fees, Subscriptions & Promotions	(61,781)	2,249	0	0	0	0	0	0	0	0	0	(59,532)	20
21	Clerical & General Office Expenses	(32,417)	184,367	0	0	0	0	0	0	0	0	0	151,950	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,892	0	0	0	0	0	0	0	0	0	17,892	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	8,948	23,414	0	0	0	0	0	0	0	0	32,362	26
27	Other (specify):*	(184,624)	0	0	0	0	0	0	0	0	0	0	(184,624)	27
28	TOTAL General Administration	(281,294)	(782,506)	30,336	0	0	0	0	0	0	0	0	(1,033,464)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(293,274)	(764,942)	30,336	0	0	0	0	0	0	0	0	(1,027,880)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(50,884)	5,664	169,157	0	0	0	0	0	0	0	0	123,937	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,176)	0	668,521	0	0	0	0	0	0	0	0	657,345	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	28,393	(1,182,600)	0	0	0	0	0	0	0	0	(1,154,207)	34
35	Rent-Equipment & Vehicles	0	11,970	0	0	0	0	0	0	0	0	0	11,970	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(62,060)	46,027	(344,922)	0	0	0	0	0	0	0	0	(360,955)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(355,334)	(718,915)	(314,586)	0	0	0	0	0	0	0	0	(1,388,835)	45

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE	
				CRESTWOOD HEIGHTS NURSING CENTRE		
					MORTON GROVE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 17,564	$ 17,564	1
2	V	17	ADMINISTRATIVE	1,035,422	MR. BELLOWS OWNS 22% OF THIS FACILITY		28,965	(1,006,457)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		10,495	10,495	3
4	V	20	DUES & SUBSCRIPTIONS		" "		2,249	2,249	4
5	V	21	CLERICAL		" "		184,367	184,367	5
6	V	24	TRAVEL		" "		17,892	17,892	6
7	V	26	INSURANCE		" "		8,948	8,948	7
8	V	30	DEPRECIATION		" "		5,664	5,664	8
9	V	34	RENT		" "		28,393	28,393	9
10	V	35	RENT-EQUIPMENT		" "		11,970	11,970	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,035,422			$ 316,507	$ * (718,915)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ (1,182,600)	15
16	V	19	ACCOUNTING FEES		" "		5,750	5,750	16
17	V	26	MORTGAGE INSURANCE		" "		23,414	23,414	17
18	V	30	DEPRECIATION-BLDG IMP.		" "		160,772	160,772	18
19	V	30	DEPRECIATION - EQUIP. & FURN		" "		8,385	8,385	19
20	V	32	AMORTIZATION - MTG COST		" "		96,601	96,601	20
21	V	32	MORTGAGE INTEREST		" "		571,920	571,920	21
22	V	19	DATA PROCESSING				1,172	1,172	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,182,600			$ 868,014	$ * (314,586)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	22%	SEE ATTACHED	4.39	18.52	SALARY	28,965	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,965		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	$ 94,929	$ 94,929	91,299	$ 17,564	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	91,299	28,965	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		91,299	10,495	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		91,299	2,249	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		91,299	35,401	5
6	21	CLERICAL	HOURS	1	1	148,966	148,966	1	148,966	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		91,299	17,892	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		91,299	8,948	8
9	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611		91,299	5,664	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459		91,299	28,393	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	493,454	9	64,696		91,299	11,970	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,057,922	$ 403,876		$ 316,507	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$84,053.00	09/97	4,897,900			7.3750	561,151	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		113,573				96,537	3
4	GMAC		X	MORTGAGE	$101,139.93	12/03	4,897,900	4,897,900	12/38	0.0535	10,769	4
5	GMAC		X	LOAN COST	AMORT - 35 YEARS		54,329	54,265			64	5
	Working Capital											
6	AMERICAN NATL. BANK		X	WORKING CAPITAL	DEMAND	VARIES	323,671	1,050,000	DEMAND	PRIME+	43,888	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,191,428	1,683,594	DEMAND	VARIES	66,595	7
8	LOAN FROM PARTNERS	X		WORKING CAPITAL	DEMAND	12/31/99	100,000	148,641	DEMAND	8.2500	11,328	8
9	TOTAL Facility Related				$185,192.93		$ 11,578,801	$ 7,834,400			$ 790,332	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,578,801	$ 7,834,400			$ 790,332	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,414 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 470,274	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 471,212	2
3. Under or (over) accrual (line 2 minus line 1).		$ 938	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 456,606	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 39,615 **For** 96/97 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (39,615)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 417,929	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	481,940	8
1999	471,970	9
2000	450,237	10
2001	467,362	11
2002	471,212	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-03-303-011-0000	NURSING HOME	$ 158,940.22	$ 158,940.22
2.	28-03-303-012-0000	NURSING HOME	$ 289,327.08	$ 289,327.08
3.	28-03-303-021-0000	NURSING HOME	$ 1,652.49	$ 1,514.78
4.	28-03-303-022-0000	NURSING HOME	$ 1,652.49	$ 1,514.78
5.	28-03-303-023-0000	NURSING HOME	$ 6,093.12	$ 5,585.36
6.	28-03-303-024-0000	NURSING HOME	$ 9,559.51	$ 8,762.89
7.	28-03-303-038-0000	NURSING HOME	$ 5,567.12	$ 5,567.12
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 472,792.03	$ 471,212.23

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,000	1972	$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		$ 335,752	3

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	303		1974	1974	$ 2,091,708	$ 26,548	35	$ 59,763	$ 33,215	$ 1,787,910	4
5			1980	1980	3,400		35	100	100	2,350	5
6	SEC 754 AJ			1992	584,054	22,374	31.5	18,541	(3,833)	213,224	6
7	SEC 754 AJ			2001	24,100	876	27.5	876		2,628	7
8											8
	Improvement Type**										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466		20			38,466	12
13	IMPROVEMENTS			1985	18,271	694	10		(694)	18,271	13
14	IMPROVEMENTS			1985	1,200	62	20	60	(2)	1,110	14
15	IMPROVEMENTS			1985	32,506	1,691	15		(1,691)	32,506	15
16	IMPROVEMENTS			1986	76,557	3,982	20	3,828	(154)	66,984	16
17	IMPROVEMENTS			1986	16,943	881	10		(881)	16,943	17
18	IMPROVEMENTS			1986	1,559	81	25	62	(19)	1,085	18
19	IMPROVEMENTS			1987	23,951	855	20	1,198	343	19,758	19
20	IMPROVEMENTS			1987	22,863	831	20	1,143	312	18,860	20
21	IMPROVEMENTS			1988	20,627	1,530	20	1,031	(499)	11,819	21
22	IMPROVEMENTS			1989	35,057	484	31.5	1,113	629	16,518	22
23	IMPROVEMENTS			1990	50,320	1,830	31.5	1,598	(232)	21,112	23
24	IMPROVEMENTS			1991	53,090	1,931	31.5	1,684	(247)	20,766	24
25	IMPROVEMENTS			1992	53,668	1,952	31.5	1,704	(248)	19,628	25
26	IMPROVEMENTS			1992	51,711	3,447	31.5	3,447		39,210	26
27	IMPROVEMENTS			1993	42,479	1,545	15	1,090	(455)	11,200	27
28	IMPROVEMENTS			1993	78,601	2,858	39	2,495	(363)	26,865	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		62,239	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		6,075	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		17,262	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		1,915	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		2,756	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COOLING TOWER REPLACEMENT	1995	$ 15,650	$ 569	27.5	$ 569	$	$ 4,597	37
38	HAND RAILS/TILING ROOF	1996	103,547	3,765	27.5	3,765		28,540	38
39	HAND RAILS/TILING ROOF	1996	877	32	27.5	32		234	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		15,348	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		16,020	41
42	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		98,326	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		10,492	43
44	WINDOW/OURTOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		17,680	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		6,935	45
46	ELECTRICAL WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		953	46
47	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		7,585	47
48	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		196	48
49	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		2,080	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		3,770	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		585	51
52	BOILER VALVE	1998	5,450	198	27.5	198		998	52
53	WALLCOVERING	1999	2,206	80	27.5	80		467	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		958	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		623	55
56	REMODEL - NURSES STATIONS	2000	25,135	914	27.5	914		3,237	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		3,517	57
58	ROOF WORK	2000	11,384	414	27.5	414		1,363	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAI	2000	23,240	845	27.5	845		2,711	59
60	REMODEL - NURSES STATIONS	2000	10,730	390	27.5	390		1,219	60
61	CLOSET DOORS - 2, 3, AND 4TH FLOOR NURSES STATIONS	2001	1,900	69	27.5	69		204	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		109	62
63	RENOVATE - 3A, 4B, AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		631	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		1,672	64
65	DRYWALL AND PAINT - ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		173	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		1,497	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	496	27.5	496		1,013	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,706,519	$ 123,135		$ 148,416	$ 25,281	$ 2,757,739	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,706,519	$ 123,135		$ 148,416	$ 25,281	$ 2,757,739	1
2									2
3	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		235	3
4	KITCHEN FLOOR - REMOVE OLD AND INSTALL NEW TILI	2002	3,086	112	27.5	112		210	4
5	REPLACE 49 DOORS AND 1ST & 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		1,596	5
6	BUILD NEW SMOKING LOUNGE	2002	3,596	131	27.5	131		235	6
7	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	120	27.5	120		215	7
8	INSTALL WALL COVERING - ROOM 223	2002	1,800	65	27.5	65		117	8
9	REBUILD AND PREP WALLS - RMS 234, 334 AND LOUNGE	2002	4,000	145	27.5	145		248	9
10	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	55	27.5	55		89	10
11	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	550	27.5	550		802	11
12	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		115	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	80	27.5	80		110	13
14	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,150	27.5	4,150		5,015	14
15	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	5,266	27.5	5,266		5,266	15
16	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	292	27.5	292		292	16
17	RESURFACE AND PAVE PARKING LOT	2003	3,697	123	15	123		123	17
18	ALUMINUM ROOF	2003	1,700	28	27.5	28		28	18
19	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	154	27.5	154		154	19
20									20
21			ADJ TO SL	25,281			(25,281)		21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,233,167	$ 160,772		$ 160,772	$	$ 2,772,589	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 908,911	$ 83,112	$ 85,280	$ 2,168	3-10 YRS	$ 509,081	71
72	Current Year Purchases	97,524	58,148	5,096	(53,052)	3-10 YRS	5,096	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	487,595	14,049	14,049			482,275	74
75	TOTALS	$ 1,494,030	$ 155,309	$ 104,425	$ (50,884)		$ 996,452	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,062,949	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 316,081	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 265,197	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (50,884)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,769,041	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 31,845 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 JEEP CHEROKEE	$ 615.89	$ 8,077	17
18	FACILITY USE	2002 FORD CLUB WAG	675.97	6,892	18
19					19
20					20
21	TOTAL		$ #######	$ 14,969	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 238,414	$		$ 238,414	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			51,696			51,696	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			268,088			268,088	4
5	Physician Care	39-3	visits			315			315	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify): MEDICAL SUPPL.	39-2					321,157		321,157	13
14	TOTAL			$		$ 558,513	$ 321,157		$ 879,670	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 223,377	$ 1,414,681	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 86,476)	2,496,040	2,496,040	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,111	212,316	6
7	Other Prepaid Expenses	44,253	44,363	7
8	Accounts Receivable (owners or related parties)	16,538	1,931,908	8
9	Other(specify): ESCROW DEPOSITS		548,065	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,855,319	$ 6,647,373	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		2,529,906	15
16	Equipment, at Historical Cost	977,432	1,421,032	16
17	Accumulated Depreciation (book methods)	(825,037)	(3,381,235)	17
18	Deferred Charges	4,348	58,613	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROG.		80,057	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 156,743	$ 3,280,968	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,012,062	$ 9,928,341	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 667,562	$ 701,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	525,979	525,979	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	246,834	246,834	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,960	31,960	31
32	Accrued Real Estate Taxes(Sch.IX-B)		456,606	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA			36
37	MANAGEMENT FEES	831,105	831,105	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,303,440	$ 2,793,556	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,949,025	2,882,235	39
40	Mortgage Payable		4,897,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,949,025	$ 7,780,135	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,252,465	$ 10,573,691	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,240,403)	$ (645,350)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,012,062	$ 9,928,341	48

*(See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,631,869)	1
2	Restatements (describe):		2
3	**2002 DEPRECIATION ADJ.**	(31,632)	3
4	**ROUNDING ADJ.**	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,663,500)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(326,903)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(250,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (576,903)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,240,403)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,841,735	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,841,735	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,176	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,176	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,852,911	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,866,867	31
32	Health Care	4,542,154	32
33	General Administration	3,809,239	33
	B. Capital Expense		
34	Ownership	1,915,301	34
	C. Ancillary Expense		
35	Special Cost Centers	879,670	35
36	Provider Participation Fee	165,893	36
	D. Other Expenses (specify):		
37	VENDING COSTS	690	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,179,814	40
41	**Income before Income Taxes (line 30 minus line 40)****	(326,903)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (326,903)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,981	2,288	$ 85,504	$ 37.37	1
2	Assistant Director of Nursing	3,742	4,130	116,243	28.15	2
3	Registered Nurses	32,450	34,420	894,802	26.00	3
4	Licensed Practical Nurses	36,793	38,424	788,653	20.53	4
5	Nurse Aides & Orderlies	143,974	153,901	1,610,457	10.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,557	1,685	17,163	10.19	7
8	Rehab/Therapy Aides	7,477	8,359	116,119	13.89	8
9	Activity Director	1,869	2,022	28,604	14.15	9
10	Activity Assistants	21,329	22,413	226,445	10.10	10
11	Social Service Workers	8,541	9,010	154,428	17.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,367	12,472	139,994	11.22	14
15	Cook Helpers/Assistants	38,369	40,594	338,994	8.35	15
16	Dishwashers					16
17	Maintenance Workers	7,042	7,302	86,009	11.78	17
18	Housekeepers	33,213	35,528	321,465	9.05	18
19	Laundry	14,230	14,980	121,814	8.13	19
20	Administrator	2,776	2,776	95,941	34.56	20
21	Assistant Administrator	1,917	2,086	69,607	33.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,461	15,627	278,579	17.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,104	10,925	139,504	12.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	393,192	418,942	$ 5,630,325 *	$ 13.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	275	$ 21,405	1-3	35
36	Medical Director	485	35,000	9-3	36
37	Medical Records Consultant	71	2,627	10-3	37
38	Nurse Consultant	1,343	56,398	10-3	38
39	Pharmacist Consultant	96	3,600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	153	8,109	12-3	45
46	Other(specify) WOUND CARE	40	3,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,463	$ 130,139		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN RIPSTEIN	ADMIN		$ 48,125
DIANE WALKER	ASST ADMIN		69,607
PAT BARROWS	ADMIN		47,816
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,548

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 1,035,422
TOTAL (agree to Schedule V, line 17, col. 3)		$ 1,035,422
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		465,847
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 465,847

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 122,361
Unemployment Compensation Insurance		62,444
FICA Taxes		419,555
Employee Health Insurance		403,151
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,980
EMPLOYEE PHYSICAL EXAMS		160
PENSION/PROFIT SHARING PLANS		11,190
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,022,841

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,218
Health Care Worker Background Check	2,014
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	57,535
TRUST/FRANCHISE/CONTRIB/ETC	4,246
LICENSES & PERMITS	1,331
DUES & SUBSCRIPTIONS	15,088
MGMT CO ALLOCATION	2,249
TRUST/FRANCHISE/CONTRIB/ETC	(4,246)
Less: Public Relations Expense	(0)
Non-allowable advertising	(43,315)
Yellow page advertising	(14,220)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,900

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	350
RELATED PARTY	17,892
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,242

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2000	$ 7,387	3	$ 1,231	$ 2,462	$ 2,462	$ 1,232	$	$	$	$	$
2	PAINT/DECORATING	2001	1,790	3		298	597	597	298				
3	PAINT/DECORATING	2002	5,817	3			970	1,939	1,939	969			
4													
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20	TOTALS		$ 14,994		$ 1,231	$ 2,760	$ 4,029	$ 3,768	$ 2,237	$ 969	$	$	$

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. COUNCIL ON LTC $18158.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,008** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **165,893**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees